

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13684

CERTIFICATE OF DEATH

13688

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN lb 10yr 9mo 14 days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 843 N. Eutaw Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Anthony First Middle Last Baglione		4. DATE OF DEATH Month Day Year 10 15 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-15-09
9. AGE (In years lost birthday) 58 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 30-4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT U.S.A. COUNTRY? naturalized	
13. FATHER'S NAME Joseph Baglione		14. MOTHER'S MAIDEN NAME Bessie Tomeo	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 213-09-1535	
17. INFORMANT Address Sykesville, Maryland Springfield Hospital records			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pyelonephritis and suppurative nephritis 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Psychotic Depressive reaction		INTERVAL BETWEEN ONSET AND DEATH Days-weeks Days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 1-16- 19 56 , to 10-15- 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 10-15- 19 67 , and that death occurred at 10:45 AM from causes and on the date stated above.			
22a. SIGNATURE Suha Ozgun		22b. DATE SIGNED 10-16-67	
22c. PHYSICIAN'S NAME (Type) Suha Ozgun, M.D.		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-67	
23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cemetery		23d. LOCATION (City or Town) (County) (State) 7401 German Hill Rd., Md.	
24. FUNERAL DIRECTOR Charles L. Geiler		25a. REC'D BY REGISTRAR OCT 20 1967	
ADDRESS 6224 Eastern Ave. Balto., 21224, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

02362

50-81-01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 1y. 21days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Braddock Heights		10-2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Box 57	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle Agnes Last Barthel		4. DATE OF DEATH Month 10 Day 8 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/15/91
9. AGE (In years last birthday) yrs. 75		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) social work		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Woods		14. MOTHER'S MAIDEN NAME Dorothy X Bridget Gartland	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 055-24-3888	
17. INFORMANT Springfield Hospital records, Sykesville, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome with senile brain disease with psychotic reaction		19. WAS AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 9/11/ , 19 66 , to 10/8/ , 19 67 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on 10/8/ 19 67 , and that death occurred at 9:45 a.m. from causes and on the date stated above.			
22a. SIGNATURE Carlos G. Lavin, M.D.		22b. DATE SIGNED 10/9/67	
22c. PHYSICIAN'S NAME (Type) Carlos G. Lavin, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/11/67	
23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) Middle Village, N. Y.	
24. FUNERAL DIRECTOR M. R. Etchison & Son, Frederick, Md. 21701		25a. REC'D BY REGISTRAR ACT 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

M. R. Richardson & Son, Frederick, Md. 21701

St. John's Cemetery

Midvale Village, N. Y.

Springfield State Hospital
Springfield, Maryland

10/1/57

General brain syndrome with senile brain disease with psychotic reaction x

no

02-2-3888

xxxxxx Bridget Garland

social work

New York

USA

white

x

12/1/51

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Marx

James

Barnard

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Springfield State Hospital

Box 21

J. J. Sullivan

Braddock Heights

Quincy

Marjorie

Frederick

13586

CERTIFICATE OF DEATH

13690

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 11 yr. 2 mo. 6 da	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL			d. STREET ADDRESS 713 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First DONATO Middle NMN Last BASILE			4. DATE OF DEATH Month 10 Day 16 Year 19 67		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 11/29/1884		9. AGE (In years last birthday) 82 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Iron Foreman		10b. KIND OF BUSINESS OR INDUSTRY cement mfg.		11. BIRTHPLACE (County & State, or foreign country) Italy	
13. FATHER'S NAME Stephen Basile			12. CITIZEN OF WHAT COUNTRY? 1st papers		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Springfield State Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding gastric ulcer DUE TO (b) Bronchopneumonia DUE TO (c) Arteriosclerotic heart disease					INTERVAL BETWEEN ONSET AND DEATH weeks days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) reaction CBS assoc. with circulatory distb. with cerebral art. with psychotic					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from 8/10/56 , 19__, to 10/16/67 , 19__, that (I) (we) last saw the deceased alive on 10/16/67 , 19__, and that death occurred at __ M, from causes and on the date stated above.					
22a. SIGNATURE <i>Isaac E. Hapner</i>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/17/67
22c. PHYSICIAN'S NAME (Type) Isaac E. Hapner, M.D.			22d. ADDRESS		
23a. BURIAL, CREMATION, or REMOVAL (Specify) burial	23b. DATE THEREOF 10-19-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR <i>Frank L. Mimmich</i>			25a. REC'D BY REGISTRAR OCT 20 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

1958

UNITED STATES OF AMERICA

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Washington

Department

General

At the 1st of January 1958

STATION

His Majesty's

SECRETARY OF THE AIR FORCE

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 1 yr 11 mo 11 da	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 17 W. Main Street	
3. NAME OF DECEASED (Type or print) First JAMES Middle GORDON Last BEEMAN		4. DATE OF DEATH Month 10 Day 26 Year 19 67	
5. SEX Male	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/22/12
9. AGE (In years last birthday) 55 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY STATE ROADS	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Beeman		14. MOTHER'S MAIDEN NAME Laura Jane Horton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-10-9859	
17. INFORMANT Springfield Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Confluent bronchopneumonia 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Days Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis with behavioral reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/12/65 to 10/26/67 , that (I) (we) lost saw the deceased alive on 10/26 19 67 , and that death occurred at 8:15 PM , from causes and on the date stated above.			
22a. SIGNATURE Alfredo M. Labrit M.D.		22b. DATE SIGNED 10/26/67	
22c. PHYSICIAN'S NAME (Type) Alfredo M. Labrit, M. D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 29, 1967	23c. NAME OF CEMETERY OR CREMATORY FROSTBURG MEM. PARK	23d. LOCATION (City or Town) (County) (State) FROSTBURG MARYLAND
24. FUNERAL DIRECTOR M. SOLERS HAFER-SOLERS		25. REGISTRAR'S SIGNATURE Charles J. ...	

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CONTINUATION OF DISBURSEMENTS

ALLEGEDLY

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13688

CERTIFICATE OF DEATH

13692

1. PLACE OF DEATH a. COUNTY <i>Carroll</i> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Westminster</i> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Carroll County General Hospt.</i>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>Md.</i> b. COUNTY <i>Balto.</i> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Owings Mills</i> d. STREET ADDRESS <i>11137 Reisterstown Road</i> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <i>Edith</i> Middle <i>E.</i> Last <i>Bosley</i>			4. DATE OF DEATH Month <i>10</i> Day <i>14</i> Year <i>1967</i>		
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>Dec. 23, 1900</i>		9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months <i>03</i> Days <i>2</i> IF UNDER 24 HRS. Hours <i>03</i> Min. <i>2</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Employed at Landray</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Balto. Co. Md.</i>	
13. FATHER'S NAME <i>Noah A. Bosley</i>		14. MOTHER'S MAIDEN NAME <i>Violet Harris</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>216-05-1686</i>		17. INFORMANT Address <i>Mrs. Lillian G. Baublitz Owings Mills, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CONGESTIVE HEART FAILURE</i> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>ARTERIOSCLEROTIC HEART DISEASE</i> (c) <i>YEARS</i> (e), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <i>DIABETES MELLITUS</i> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20c. TIME OF INJURY Month, Day, Year <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <i>10/14</i> , 19 <i>67</i> , to <i>10/14</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>10/14</i> , 19 <i>67</i> , and that death occurred at <i>6:30</i> P.M., from the causes and on the date stated above.					
22a. SIGNATURE <i>Vincent J. Kroc Jr.</i> M.D.			22b. DATE SIGNED <i>10/14/67</i>		
22c. PHYSICIAN'S NAME (Type)			22d. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Oct. 17, 67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wesley Cemetery</i>	
23d. LOCATION (City, town or county) <i>Carroll Co. Md.</i>		(State)			
24. FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Eline & Sons</i>			25a. RECEIVED BY REGISTRAR <i>OCT 17 1967</i> 25b. REGISTRAR'S SIGNATURE <i>James Judge</i>		
ADDRESS <i>Reisterstown, Md.</i>			DATE		

1968

RECEIVED

1968

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VR A15 (4)
15M 4-64

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13689					13693						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY Carroll MARYLAND					a. STATE Maryland b. COUNTY						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 304						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 2025 N. Bentalou St.			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)			First		Middle		Last		4. DATE OF DEATH		
			Mary		T.		Boyd		Month October Day 31 Year 1967		
5. SEX Female		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-22-02		9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY Private Family		11. BIRTHPLACE (County & State, or foreign country) Virginia (Millwood)			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Taylor, dec.					14. MOTHER'S MAIDEN NAME Rebecca						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 215-22-0212-A		17. INFORMANT Hospital Records			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Bronchopneumonia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Bilateral old sub-dural hematomas										INTERVAL BETWEEN ONSET AND DEATH years days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 10-24 , 19 67 , to _____, 19____, that (I) (we) last saw the deceased alive on October 31 19 67 , and that death occurred at 7:10 p.m. from the causes and on the date stated above.										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE Sergio J. Palacio					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) Sergio J. Palacio, M.D., Attending physician			
22d. ADDRESS Springfield State Hospital, Sykesville,					22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22f. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/3/67		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial Park			23d. LOCATION (City, town or county) Md. (State) Arbutus Balto Co, Md			
24. FUNERAL DIRECTOR Herbert E. Nutter					ADDRESS 3035 W. North Ave			25a. REC'D BY REGISTRAR NOV 3 1967			
								25b. REGISTRAR'S SIGNATURE Charles Judge			

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By weight

Springfield, Mass. 01104

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Nov 3 1981

VR A15 (4)
25M 1/67

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112

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

13690

13694

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY FREDERICK	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE		c. LENGTH OF STAY IN 1b 1 yr. 1 da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRINGFIELD STATE HOSPITAL		d. STREET ADDRESS 143 W. Patrick Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BERNARD Middle BELL Last BROOKS		4. DATE OF DEATH Month 10 Day 29 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-21-96 08/21/96
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 29 Hours 19 Min. 67	11. IF UNDER 24 HRS. Hours 19 Min. 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deliveryman		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (County & State, or foreign country) Maryland Kansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Alvey Thomas Brooks		14. MOTHER'S MAIDEN NAME Mildred Bell Emma Bell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) yes 1916-19		16. SOCIAL SECURITY NO. 217-10-0192	
17. INFORMANT HOSPITAL RECORDS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumoniz - left lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease with old DUE TO (c) myocardial infarction			INTERVAL BETWEEN ONSET AND DEATH days years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with cerebral arteriosclerosis with psychotic reaction			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 08/22 , 19 96 , to 10/29 , 19 67 , that (I) (we) saw the deceased alive on 10/29 , 19 67 , and that death occurred at 9:20A , from causes and on the date stated above			
22a. SIGNATURE Rafi Q. Iqbal		22b. DATE SIGNED 10/29/67	
22c. PHYSICIAN'S NAME (Type) Rafi Q. Iqbal, M. D.		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF Nov. 1-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR M.R. Etchison & Son		25a. REC'D BY REGISTRAR DATE OCT 31 1967	
ADDRESS Whitmore Frederick, Md. 21701		25b. REGISTRAR'S SIGNATURE Charles Judge	

13390

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DEPARTMENT OF HEALTH

OFFICE OF THE ATTORNEY GENERAL
STATE OF NEW YORK

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH			
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13691		MEDICAL EXAMINER'S CERTIFICATE OF DEATH	
13695			
1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u>		c. LENGTH OF STAY IN lb <u>Life</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Mt. Airy</u>		d. STREET ADDRESS <u>R. D. 4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R. D. 4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>T.</u> Last <u>B USSARD</u>		4. DATE OF DEATH Month <u>10</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15, 1870</u>
9. AGE (In years last birthday) <u>97</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>16</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Truck Farmer</u>	
11. BIRTHPLACE (State or foreign country) <u>Howard Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Randolph Bussard</u>		14. MOTHER'S MAIDEN NAME <u>Mary A. Kaire</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-54-7719</u>	
17. INFORMANT <u>Mrs. Mary Brothers</u>		Address <u>R.D. Mt. Airy, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO (b) <u>Arterio Sclerotic Cardio</u> DUE TO (c) <u>Vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Several yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. Glenn Speicher</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>10-16-67</u>	
Address (Street, city, town, or county) <u>135 E. Main St. Carroll</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>10/19/1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethesda Cemetery</u>	
23d. LOCATION (City or town) (County) <u>Carroll</u>			
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>		ADDRESS <u>Box 241 Sykesville, Md.</u>	
25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>		DATE	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

1961

UNITED STATES DEPARTMENT OF AGRICULTURE

1961

1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13692 CERTIFICATE OF DEATH 13696											
1. PLACE OF DEATH a. COUNTY <u>CARROLL CO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>UNION MILLS</u>				c. LENGTH OF STAY IN 1b <u>34 MO.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>MEADOW CONSUM. HOME</u>					d. STREET ADDRESS <u>222 Penna Ave.</u>						
3. NAME OF DECEASED (Type or print) First Middle Last <u>ALICE MARY BYERS</u>			4. DATE OF DEATH Month Day Year <u>OCT. 7 19 67</u>								
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 28, 1882</u>		9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE-WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL CO MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S. 9.</u>		
13. FATHER'S NAME <u>CHARLES SHIPLEY</u>					14. MOTHER'S MAIDEN NAME <u>SARAH BOLLINGER</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>214-01-1700A</u>		17. INFORMANT <u>STERLING J. BYERS</u>			Address <u>SAME ADDRESS</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Congestive heart failure & Myocardial Infarct.</u> DUE TO (b) <u>Generalized Atherosclerosis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <u>2 hr.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>7/25/67</u> , 19 <u>67</u> , to <u>10/7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>8/15</u> , 19 <u>67</u> , and that death occurred at <u>7:35</u> pm, from the causes and on the date stated above.											
22a. SIGNATURE <u>William R. O'Rourke</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/9/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>William R. O'Rourke</u>					22d. ADDRESS <u>150 W. Main St. Westminster, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>OCT 11, 67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY RURAL, WESTMINSTER</u>			23d. LOCATION (City, town or county) (State) <u>MD.</u>			
24. FUNERAL DIRECTOR <u>J. J. Myers, Jr., Westminster, Md.</u>					25a. REC'D BY REGISTRAR <u>OCT 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

09351

Convolvulus altheoides

William R. Oron
William R. Oron

120 W. Main St. Westchester, NY 10594

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13693

CERTIFICATE OF DEATH

13697

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>7mos. 21dys.</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>1935 Pennsylvania Ave.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>NAOMI</u> Middle <u>(NMN)</u> Last <u>CARROLL</u>				4. DATE OF DEATH Month <u>OCTOBER</u> Day <u>4</u> Year <u>1967</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8-20-1894</u>	
9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Jasper Whitney</u>				14. MOTHER'S MAIDEN NAME <u>Sally (last name unk.)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-7302</u>		17. INFORMANT Address <u>Records, Springfield State Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Severely infected multiple decubitus ulcers</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Years</u> <u> </u> <u>Years</u> <u> </u> <u>Weeks or Months</u> <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>2-13-67</u> , 19 <u> </u> , to <u>10-4-67</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>10-4-67</u> , 19 <u> </u> , and that death occurred at <u>12:30 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. Antonius Glahn, M.D.</u>				22b. DATE SIGNED <u>10-4-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Antonius Glahn, M.D.</u>	
22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10-7-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Cem. Pk.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arbutus Maryland</u>	
24. FUNERAL DIRECTOR <u>Kelson Funeral Home 1348 Calhoun St.</u>				25a. REC'D BY REGISTRAR <u>OCT 6 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

12804

INSTITUTION OF HEALTH

13883

13883

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13694 Items #8 & 9 & 10a Film #G393 10/16/67 ph									
13698									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto. City				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 24yrs. 4mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 105 SELFRIDGE RD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John Henry Chronister					4. DATE OF DEATH Month October Day 9 Year 19 67				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-11-83/ 1882		9. AGE (In years last birthday) 84/85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Night Watchman Handler					10b. KIND OF BUSINESS OR INDUSTRY Penn. Railroad			11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Samuel Chronister					14. MOTHER'S MAIDEN NAME CATHERINE SMALL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Springfield State Hospital Records.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic cardiovascular disease DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH Weeks Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 6-30-43 , 19____, to 10-9-67 , 19____, that (I) (we) last saw the deceased alive on 10-9-67 , 19____, and that death occurred at 3:00 AM , from causes and on the date stated above.									
22a. SIGNATURE <i>Glocrito G. Sagisi</i>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 10-9-67	
22c. PHYSICIAN'S NAME (Type) Glocrito Sagisi, M.D.					22d. ADDRESS Springfield Hosp. Sykesville, Md.				
23a. BURIAL CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/12/67		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL			23d. LOCATION (City or Town) (County) (State) BALTO. MD		
24. FUNERAL DIRECTOR J.C. CONNELLY SONS					ADDRESS 300 MACE		25a. REC'D BY REGISTRAR OCT 13 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

13384

REQUIREMENT OF LEAD

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13695					13699				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY <u>Carroll</u> MARYLAND					a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hampstead</u>				
c. LENGTH OF STAY IN 1b <u>2 1/2 yrs</u>					d. STREET ADDRESS <u>W. Main Street</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Longview Nursing Home</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First <u>DANNIE</u> Middle <u>Virgie</u> Last <u>Cox</u>					Month <u>10</u> Day <u>31</u> Year <u>1967</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 14 1888</u>		9. AGE (In years last birthday) <u>78</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bolton County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		IF UNDER 1 YEAR Months Days Hours Min.	
13. FATHER'S NAME <u>John H.C. HARE</u>					14. MOTHER'S MAIDEN NAME <u>Mary SEARS</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>216-07-2613</u>		17. INFORMANT Address <u>Lo Ray HARE Parkton Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Coronary Artery Disease</u> DUE TO									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 1</u> , 19 <u>65</u> , to <u>NOV 31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10-27</u> , 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Joseph E. Bush M.D.</u>					22b. DATE SIGNED <u>11-1-67</u>				
22c. PHYSICIAN'S NAME (Type) <u>Joseph E. Bush M.D.</u>					22d. ADDRESS <u>Hampstead Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>11-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>FOREST BAPTIST Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>PARKTON Md.</u>			
24. FUNERAL DIRECTOR <u>John E. Hoff</u>					25a. REC'D BY REGISTRAR <u>HAMPSTEAD, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>		

13282

13282

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13696

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13700

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) UNION BRIDGE RURAL		c. LENGTH OF STAY IN 1b HOURS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MT UNION		d. STREET ADDRESS MT UNION	
3. NAME OF DECEASED (Type or print) GEORGE PAUL CROUSE		4. DATE OF DEATH Month 10 - Day 9 - Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 18-1897 TO
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		9b. KIND OF BUSINESS OR INDUSTRY OWN FARM	
10a. BIRTHPLACE (State or foreign country) MARYLAND		10b. CITIZEN OF WHAT COUNTRY? USA	
11. FATHER'S NAME ULYSSES CROUSE		12. MOTHER'S MAIDEN NAME BURTON BOND	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		14. SOCIAL SECURITY NO. 217-36-3862	
15. INFORMANT HELEN L CROUSE KEYMAR RURAL MD		Address	
16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 9121 IMMEDIATE CAUSE (a) Fractured Skull + Multiple Fractures + Internal Injuries Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Stripped bare bones taken off on silage blower belt caught plants	
20c. TIME OF INJURY Month, Day, Year 2:59 p.m. 10-9-67	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm	20f. (City or town) Carroll (State) MD
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W Glenn Speicher		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W GLENN SPEICHER		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/11/67	
23c. NAME OF CEMETERY OR CREMATORY LUTHERAN-UNIONTOWN		23d. LOCATION (City or town) (County) (State) Westminster Carroll MD	
24. FUNERAL DIRECTOR BO Hartzler + Sons Union Bridge		25a. REC'D BY REGISTRAR OCT 13 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE g Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, 3 and 4 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 396 12-21-67 MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
13697						13701					
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville				c. LENGTH OF STAY IN 1b 1 mo. 22 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital						d. STREET ADDRESS 3835 Sequoia Avenue					
3. NAME OF DECEASED (Type or print) First Middle Last BERNARD GILBERT DANGERFIELD, Jr.						4. DATE OF DEATH Month 10 Day 24 Year 1967					
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-12-44		9. AGE (In years last birthday) yrs. 23		IF UNDER 1 YEAR Months 10 Days 24 Hours 19 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Bernard G. Dangerfield, Sr.						14. MOTHER'S MAIDEN NAME Carrie Jones					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 1966		17. INFORMANT Records, Springfield State Hospital		Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 3002 IMMEDIATE CAUSE (a) Pending study of brain and tissues DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fatal Catatonia DUE TO (c) _____											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE W. Glenn Speicher M.D.						22. DATE SIGNED 10-25-67					
EXAMINER'S NAME (Type) W. Glenn Speicher, M. D.						135 Carroll Baltimore Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-30-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore					
24. FUNERAL DIRECTOR Morton E. Dyett F.H.				ADDRESS 1701 Laurens St.				25a. REC'D BY REGISTRAR OCT 27 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13698

13702

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodbine</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Woodbine</u>	
c. LENGTH OF STAY IN 1b <u>6 Years</u>		d. STREET ADDRESS <u>R.D. 1 - Hoods Mill Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R.D. 1 - Hoods Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Worley</u> Middle <u>Davidson</u> Last <u>Davidson</u>		4. DATE OF DEATH Month <u>October</u> Day <u>6</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 23, 1923</u>
9. AGE (In years last birthday) yrs. <u>43</u>		10. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bundler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Box Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wise Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hobert Davidson</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>230-28-9791</u>	
17. INFORMANT <u>Mrs. Josephine Davidson</u>		Address <u>Same As #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the lung with cervical and</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>cerebral metastasis. Severe post radium</u> DUE TO (c) <u>and Colboitt reaction; Cardiac arrest from cerebral pressu</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Aug. 1967</u> <u>through</u> <u>10/6/67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug.</u> , 19 <u>67</u> , to <u>Oct. 6</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Oct. 6</u> , 19 <u>67</u> , and that death occurred at <u>5 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>Oct. 7, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/9/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sharon Baptist</u>		23d. LOCATION (City or Town) (County) (State) <u>Howard Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. M. Waltz</u>		25a. REC'D BY REGISTRAR <u>Box 241 Sykesville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>John A. Judge</u>		DATE <u>OCT 10 1967</u>	

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FOR STATE HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13703

13699

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. LENGTH OF STAY IN lb <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DOA CARROLL COUNTY GENERAL HOSPITAL</u>		e. STREET ADDRESS <u>316 MAIN ST</u>	
3. NAME OF DECEASED (Type or print) First <u>BESSIE</u> Middle <u>MARIE</u> Last <u>DEAL</u>		4. DATE OF DEATH Month <u>10</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 24, 1963</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. <u>4</u>
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CECIL DEAL</u>		14. MOTHER'S MAIDEN NAME <u>VELMA MCKINNEY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>CECIL DEAL</u>		Address <u>316 MAIN ST. NEW WINDSOR, MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 8124 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>multiple contusions & abrasions</u> (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ran out into main street struck by a going car</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>5:15</u> p.m. <u>10:4</u> 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>	20f. (City or town) (County) (State) <u>New Windsor Carroll Md</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>W. GLENN SPEICHER</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, county, or town) <u>135 E. W. Westminister</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>21157 Carroll Md</u>
24. FUNERAL DIRECTOR <u>W. H. Baile</u>		ADDRESS <u>NEW WINDSOR</u>	25a. REC'D BY REGISTRAR DATE <u>OCT 9 1967</u>
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

COVER

13038

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13700

CERTIFICATE OF DEATH

13704

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 27 days.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN (NMN)		4. DATE OF DEATH Month OCTOBER Day 18 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> UNK <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-1882
9. AGE (In years last birthday) yrs. 85		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unk.		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 218-54-3912	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-21-67 , 9:45 PM , 10-18-67 , 19__, that (I) (we) last saw the deceased alive on 10-18-67 19__, and that death occurred at 7:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz M.D.		22b. DATE SIGNED 10-19-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-20-67	23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery	23d. LOCATION (City or Town) (County) (State) Sykesville Md.
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR Sykesville, Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE OCT 23 1967	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13701

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13705

1. PLACE OF DEATH a. COUNTY CARROLL b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBURG c. LENGTH OF STAY IN b. 3 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MIDDLEBURG d. STREET ADDRESS _____ e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BESSIE AGNES DORSEY First Middle Last 4. DATE OF DEATH OCT 8 1967 Month Day Year		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH NOV 6 - 1900 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR 10b. KIND OF BUSINESS OR INDUSTRY SEWING 11. BIRTHPLACE (County & State, or foreign country) MARYLAND 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME WILLIAM CARBAUGH 14. MOTHER'S MAIDEN NAME CLARA FURNEY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 219-05-7241 17. INFORMANT CLARA STULTZ MIDDLEBURG MD Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Artherosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (b) 4200 a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma of the pancreas	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 7/19/67 19 to 10/2/67 19, that (I) (we) last saw the deceased alive on 10/6/67 19, and that death occurred at 1:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE J H Caricofe M.D. 22c. PHYSICIAN'S NAME (Type) J H CARICOFE		22b. DATE SIGNED 10/9/67 22d. ADDRESS UNION BRIDGE MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF OCT 11 - 1967 23c. NAME OF CEMETERY OR CREMATORY WINTERS 23d. LOCATION (City, town or county) (State) NEW WINDSOR RURAL MD		24. FUNERAL DIRECTOR'S SIGNATURE D D Hartzler & Sons ADDRESS New Windsor, Md 25a. REC'D BY REGISTRAR OCT 13 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

1051

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13702

13706

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> c. LENGTH OF STAY IN 1b <u>6 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Westminster Route 7</u> d. STREET ADDRESS <u>Mayberry</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
3. NAME OF DECEASED (Type or print) <u>Michael (none) Drabic</u>		4. DATE OF DEATH Month <u>10</u> Day <u>17</u> Year <u>1967</u>		5. SEX <u>M</u> <u>W</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 27, 1905</u>		9. AGE (In years last birthday) <u>62</u> yrs.		IF UNDER 1 YEAR Months <u>10</u> Days <u>17</u>		IF UNDER 24 HRS. Hours <u>17</u> Min. <u>1967</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Northampton, Pa.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>George Drabic</u>				14. MOTHER'S MAIDEN NAME <u>Tillie Seedor</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-07-0752</u>				17. INFORMANT <u>Doretta M. Drabic</u>				Address <u>Route 7 Westminster, Md.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c) <u>YEARS</u>																INTERVAL BETWEEN ONSET AND DEATH <u>WEEKS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>10/11, 1967</u> , to <u>10/12, 1967</u> , that (I) (we) last saw the deceased alive on <u>10/12, 1967</u> , and that death occurred at <u>7:43</u> P.M. from the causes and on the date stated above.																	
22a. SIGNATURE <u>Vincent J. Fiocco, Jr.</u> M.D.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>10/17/67</u>					
22c. PHYSICIAN'S NAME (Type) <u>Vincent J. Fiocco, Jr.</u>								22d. ADDRESS <u>Westminster, Md.</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>10/20/67</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Meadow Branch Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Westminster Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>D D Hartzler & Sons New Windsor</u>								25a. REC'D BY REGISTRAR DATE <u>OCT 20 1967</u>				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. Page 2 of 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13703

CERTIFICATE OF DEATH

13707

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 15 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES DAVID FORCE		4. DATE OF DEATH Month Day Year OCTOBER 12 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-23-06
9. AGE (In years last birthday) 61 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Force		14. MOTHER'S MAIDEN NAME Catharine Gitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 577-18-5730	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, due to probable aspiration DUE TO (b) Right heart failure DUE TO (c) Emphysema		INTERVAL BETWEEN ONSET AND DEATH Days Weeks Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-27-67 , 19 67 , to 10-12-67 , 19 67 , that (I) (we) last saw the deceased alive on 10-12-67 , 19 67 , and that death occurred at 2:10 AM , from causes and on the date stated above.			
22a. SIGNATURE Paul G. Ensor, M.D.		22b. DATE SIGNED 10/12/67	
22c. PHYSICIAN'S NAME (Type) Paul G. Ensor, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-16-67	23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery	23d. LOCATION (City or Town) (County) (State) Sykesville Md.
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md		25a. REG'D BY REGISTRAR OCT 17 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13709

STATE OF TEXAS

13709

County of _____

State of _____

13704

CERTIFICATE OF DEATH

13708

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 147 Liberty St.		d. STREET ADDRESS 147 Liberty St.	
3. NAME OF DECEASED (Type or print) HOWARD EARL FROUNFELTER		4. DATE OF DEATH Month October Day 23 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 21 Sept. 1894
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Well Drilling		10b. KIND OF BUSINESS OR INDUSTRY Water	
11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME William Frounfelter		14. MOTHER'S MAIDEN NAME Catherine Myers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 212-14-7761	
17. INFORMANT Mrs. Frances B. Frounfelter,		Address 147 Liberty St., Westminster, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Spleenic Flexure 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Melastasis & Coarctation DUE TO (c) Colon INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs Several yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jun 4 , 19 64 , to Oct 23 , 19 67 , that (I) (we) last saw the deceased alive on Sept 16 , 19 67 , and that death occurred at 4:50 M, from causes and on the date stated above.			
22a. SIGNATURE W. Glenn Speicher		22b. DATE SIGNED 10-24-67	
22c. PHYSICIAN'S NAME (Type) W. Glenn Speicher, M.D.		22d. ADDRESS Main St. Westminster, Maryland.	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 25 Oct. 1967	
23c. NAME OF CEMETERY OR CREMATORY Winters Cemetery		23d. LOCATION (City or Town) (County) (State) Carroll County, Md.	
24. FUNERAL DIRECTOR D. Hartzler & Son		25a. REC'D BY REGISTRAR OCT 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1051

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13705

Item #9 Film #G393 10/18/67 ph

CERTIFICATE OF DEATH

13709

1. PLACE OF DEATH a. COUNTY Maryland Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster 23 Park Ave.		c. LENGTH OF STAY IN lb Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Henry Griffin Jr.		4. DATE OF DEATH Month October Day 11 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/21/95
9. AGE (In years last birthday) 71 1/2 yrs.		10. USUAL OCCUPATION (Give kind of work done during week before death, if any) Restaurant Operator	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Griffin Sr.		14. MOTHER'S MAIDEN NAME Jane E. THOMAS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-24-7945a	
17. INFORMANT Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) & Arteriosclerotic Cardiovascular Disease DUE TO (c) Disease		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct. 7, 1967 , to Oct. 11, 1967 , that (I) (we) last saw the deceased alive on Oct. 11, 1967 and that death occurred at 10:30 PM from causes and on the date stated above.			
22a. SIGNATURE Paul G. Ensor MD		22b. DATE SIGNED 10/11/67	
22c. PHYSICIAN'S NAME (Type) Paul G. Ensor MD		22d. ADDRESS Springfield State Hospital Sykesville, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/14/67	23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEMETERY	23d. LOCATION (City or Town) (County) (State) WESTMINSTER RD MD
24. FUNERAL DIRECTOR J. E. Myers, Jr. Westminster, Md.		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

15370

RECEIVED IN BUREAU OF LANDS

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13706					13710						
1. PLACE OF DEATH a. COUNTY CARROLL COUNTY MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL WESTMINSTER			c. LENGTH OF STAY IN 1b 3 MOS.		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER 06.1						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) LUCA BAUGH MILL ROAD RT 3					d. STREET ADDRESS 257 E. MAIN			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CARRIE First MAE Middle HARMAN Last			4. DATE OF DEATH OCT 1 Month 1 Day 1967 Year								
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN 23, 1874		9. AGE (In years last birthday) 93 yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) CARROLL CO. MD.			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOHN WILHIDE					14. MOTHER'S MAIDEN NAME LYDIA MILLER						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 219-20-47290		17. INFORMANT MRS. ROBERT BAUMGARDNER Address RT #3 WESTMINSTER, MD.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 4221 DUE TO Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) Arterio-sclerosis								INTERVAL BETWEEN ONSET AND DEATH 5 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from May 1935 to Oct 1, 1967 , that (I) (we) last saw the deceased alive on Sept 13, 1967 , and that death occurred at 4221 M, from the causes and on the date stated above.											
22a. SIGNATURE W. C. JENNETTE					22b. DATE SIGNED OCT 2, 1967						
22c. PHYSICIAN'S NAME (Type) W. C. JENNETTE MD.					22d. ADDRESS 103 E. MAIN ST. WESTMINSTER, MD.						
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/3/67		23c. NAME OF CEMETERY OR CREMATORY WESTMINSTER CEM.			23d. LOCATION (City, town or county) (State) WESTMINSTER, MD.				
24. FUNERAL DIRECTOR James G. Saffell					25a. REC'D BY REGISTRAR Charles Judge					25b. REGISTRAR'S SIGNATURE Charles Judge	

13708

13710

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13707

13711

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster (Rural)</u>			
c. LENGTH OF STAY IN 1b <u>1 month</u>				d. STREET ADDRESS <u>Rt 3</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Jesse</u> Last <u>Hull</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/29/1880</u>	9. AGE (In years last birthday) <u>86</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farmer</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Leander Hull</u>				14. MOTHER'S MAIDEN NAME <u>MARY Luckabaugh</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-46-8439</u>		17. INFORMANT <u>Mr John Hull</u> Address <u>Westminster, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> DUE TO (c) <u>Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>67</u> , to <u>Oct 24</u> , 1967, that (I) (we) last saw the deceased alive on <u>Oct 24</u> , 1967, and that death occurred at <u>4:45</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>W H Foard</u>				22b. DATE SIGNED <u>10/24/67</u>		22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>	
22d. ADDRESS <u>Manchester, Md 21102</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>RIDERS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>RURAL, WESTMINSTER MD</u>	
24. FUNERAL DIRECTOR <u>J. E. Myers Jr. Westminster, Md</u>				25a. REC'D BY REGISTRAR <u>OCT 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

Received 11/24/1914
J. S. Rogers for Westchester, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13708

13712

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospital		d. STREET ADDRESS Rexis Avenue Perry Hall 21128	
3. NAME OF DECEASED (Type or print) First John Middle W. Last Jasper		4. DATE OF DEATH Month 10 Day 26 Year 1967	
5. SEX Male	6. COLOR OR RACE Cac	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-15-1905
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 26 Hours 10 Min. 1967	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cathe Operator		10b. KIND OF BUSINESS OR INDUSTRY Black & Decker	
11. BIRTHPLACE (County & State, or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Jasper		14. MOTHER'S MAIDEN NAME Margaret Mulhausen	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 218-03-0884	
17. INFORMANT Mrs Barbara Jasper		Address Rexis Road Perry Hall, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO (b) Coronary Thrombosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 hours		INTERVAL BETWEEN ONSET AND DEATH 3 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/26 , 19 67 , to 10/26 , 19 67 that (I) (we) last saw the deceased alive on 10/26 , 19 67 , and that death occurred at 3:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE John S. Harshey M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 10/26/67	
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22d. ADDRESS 8 Archer St. Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-30-1967	
23c. NAME OF CEMETERY OR CREMATORY St. Micheal's Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Passalun Funeral Home 7461 Belair Road		25a. REC'D BY REGISTRAR 36	
25b. REGISTRAR'S SIGNATURE Charles Judger		DATE OCT 30 1967	

13702

UNITED STATES OF AMERICA

13702



UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C.
1917

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13709

13713

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westminster		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Carroll Co. General Hospt.		d. STREET ADDRESS Trenton Mill Rd.	
3. NAME OF DECEASED (Type or print) LILYE BLANCHE JORDAN		4. DATE OF DEATH Month 10 - Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 2, 1885
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) yrs. 82
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David M. Thompson		14. MOTHER'S MAIDEN NAME Agnes Tipton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)) NO		16. SOCIAL SECURITY NO. 213-28-2604	
17. INFORMANT G. Russell Jordan		Address Hampstead, Md. 21074	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary thrombosis (acute) Sudden DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, City or Town, County, State) 356 E. 6th St. Westminster, Md.	
22. DATE SIGNED 10-15-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 18, 1967	
23c. NAME OF CEMETERY OR CREMATORY Trenton Cemetery		23d. LOCATION (City or Town) (County) (State) Westminster, Carroll	
24. FUNERAL DIRECTOR Tipton - Eline Funeral Home		ADDRESS Hampstead, Md.	
25a. REC'D BY REGISTRAR OCT 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

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VR A15
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13710 Item #16 Film #3394 11/7/67 ph 13714											
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission)					
a. COUNTY Carroll						a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Sykesville						b. COUNTY Carroll					
c. LENGTH OF STAY IN 1b 2 Weeks						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural, Taneytown, Md.					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pullens Nursing Home						d. STREET ADDRESS Mailing Address Littlestown, Pa. R. D. 1					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First Middle Last			4. DATE OF DEATH			Month Day Year		
			Charles M. Keefer			Oct 31			1967		
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5/11/1898		69 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming				10b. KIND OF BUSINESS OR INDUSTRY Farms				11. BIRTHPLACE (County & State, or foreign country) Carroll County, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME John H. Keefer				14. MOTHER'S MAIDEN NAME Susanna Hahn			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 215-32-5888				17. INFORMANT Address Mrs. Henry Eckard, Littlestown, Pa. R. D. 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Ca DUE TO Carcinoma of Bladder Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cachexia, dehydration											
INTERVAL BETWEEN ONSET AND DEATH 3 mos. 1 yr.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 20 19 67 to Oct 31 19 67 , that (I) (we) last saw the deceased alive on Oct 20 19 67 , and that death occurred at 11:30 AM, from the causes and on the date stated above.											
22a. SIGNATURE Sani Okutman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 11/1/67		
22c. PHYSICIAN'S NAME (Type) Sani Okutman						22d. ADDRESS Sykesville, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/3/67		23c. NAME OF CEMETERY OR CREMATORY St. Marys Cemetery				23d. LOCATION (City, town or county) (State) Silver Run, Carroll County, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Richard A. Little						ADDRESS Littlestown, Pa.		25a. REC'D BY REGISTRAR NOV 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13711

CERTIFICATE OF DEATH

13715

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN life	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Oaklahoma Road</u>		d. STREET ADDRESS <u>Oaklahoma Road</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Alvina</u> Middle <u>I.</u> Last <u>King</u>		4. DATE OF DEATH Month <u>October</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-28-1906</u>
9. AGE (In years last birthday) <u>60</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Clarence Thomas</u>	
14. MOTHER'S MAIDEN NAME <u>Bertha Rheubottom</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>218-32-9877</u>		17. INFORMANT <u>Mr. Harry King</u> Address <u>Sykesville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (d). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure, bronchial pneumonia,</u> DUE TO <u>Severe arthritis, Convulsive seizures</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Anemia</u>			INTERVAL BETWEEN ONSET AND DEATH <u>1960 through 10/1/67</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>9:00</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , to <u>Oct. 1, 1967</u> , that (I) (we) lost the deceased alive on <u>Oct. 1, 1967</u> , and that death occurred at <u>9:00 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Howard E. Hall</u>		22b. DATE SIGNED <u>Oct. 2, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>		22d. ADDRESS <u>Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-5-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>White Rock Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Sykesville, Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>		25a. REC'D BY REGISTRAR <u>Sykesville, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>OCT 9 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

13716

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 4yrs.3mos.27dys.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 141 S. Main St.	
3. NAME OF DECEASED (Type or print) First WESLEY Middle KIMEL Last KITCHEN		4. DATE OF DEATH Month OCTOBER Day 10 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-16-1884
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		9b. KIND OF BUSINESS OR INDUSTRY Unk.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Kitchen		14. MOTHER'S MAIDEN NAME Laura Turner	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unk.		16. SOCIAL SECURITY NO. 219-20-2632	
17. INFORMANT Records, Springfield State Hospital		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive bilateral pneumonia DUE TO (b) 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-13-63 , 19 10-10-67 , 19 10-10-67 , that (I) (we) last saw the deceased alive on 10-10-67 19 10-10-67 , and that death occurred at 10:30 PM M, from causes and on the date stated above.			
22a. SIGNATURE Glocrito G. Sagisi		22b. DATE SIGNED 10-10-67	
22c. PHYSICIAN'S NAME (Type) Glocrito G. Sagisi, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, or other disposition (Specify) UNKNOWN		23b. DATE THEREOF 10-13-1967	
23c. NAME OF CEMETERY OR CREMATORY Falling Waters Pres. Cemetery-Spring Mills, Berkeley, WVA		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR N.K. Brown Brown Funeral Home		25a. REC'D BY REGISTRAR OCT 16 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. REGISTRAR'S NAME Charles Judge	

Journal of Management Education 30(6)p. 789-804

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• *Journal of Management Education*, 2000, 24(1), 10-15

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

137112

Item #2d Film #G394 10/30/67 ph

CERTIFICATE OF DEATH

137117

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Maryland		c. LENGTH OF STAY IN 1b 8yrs. 8mons 11days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 21231			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 2208 Fleet St. Sykesville, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Felix Middle Joseph Last Kryger				4. DATE OF DEATH Month 10 Day 14 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-30-06	
9. AGE (In years last birthday) yrs. 61		IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min. 14		IF UNDER 24 HRS. Hours 14 Min. 14			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland U.S.A.	
13. FATHER'S NAME Michael Kryger				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown				16. SOCIAL SECURITY NO. 215-18-9063		17. INFORMANT Springfield Hospital Records, Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Mesenteric Thrombosis DUE TO (b) Pulmonary Emphysema DUE TO (c) Obesity				INTERVAL BETWEEN ONSET AND DEATH Hours Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Catatonic Type.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that it (this hospital) attended the deceased from 1-26-59 , 19 59 , to 10-14 , 19 67 , that it (we) last saw the deceased alive on 10-14- 19 67 , and that death occurred at 1:25A M, from causes and on the date stated above.							
22a. SIGNATURE Suha Ozgun				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Suha Ozgun				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-18-1967		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary		23d. LOCATION (City or Town) (County) (State) Baltimore, County, Maryland	
24. FUNERAL DIRECTOR Lilly & Zeiler Inc. 1901-07 Eastern Avenue				25a. REC'D BY REGISTRAR OCT 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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summa project 70-1001 CONT. section 4 of 11

13715

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b 1 HR	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL COUNTY GEN. HOSP.		d. STREET ADDRESS Box 153 Union Bridge, Md.	
3. NAME OF DECEASED (Type or print) BABY GIRL First LBS Middle CALLIST Last EST		4. DATE OF DEATH Month 10 Day 19 Year 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/19/67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) CARROLL COUNTY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN ALLEN		14. MOTHER'S MAIDEN NAME BLACK, NANCY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 776X IMMEDIATE CAUSE (a) IMMATURE DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/19 , 19 67 to 10/19 , 19 67 , that (I) (we) last saw the deceased alive on 10/19 , 19 67 and that death occurred on 10/19 , 19 67 from causes and on the date stated above.			
22a. SIGNATURE Sherman Chang		22b. DATE SIGNED 10/19/67	
22c. PHYSICIAN'S NAME (Type) Sherman, Chang, M.D.		22d. ADDRESS Westminster, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Disposed by Hosp. 20 Oct 67 Carroll County Gen. Hosp. Westminster Carroll Md.			
24. FUNERAL DIRECTOR GLENN A. FISHER Administrator		25a. REC'D BY REGISTRAR NOV 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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Final Answer.

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James M. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 2504 Moore Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First SARAH Middle HELEN Last LEBO					4. DATE OF DEATH Month OCTOBER 27, Day 19 Year 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-4-1876		9. AGE (In years last birthday) yrs. 91		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker			10b. KIND OF BUSINESS OR INDUSTRY Shoe Mfg.			11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown Martin L. Helsler					14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 183-12-2103-A			17. INFORMANT Address Records, Springfield State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Bronchopneumonia DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									INTERVAL BETWEEN ONSET AND DEATH Years Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10-26-67 , 19 to 10-27-67 , 19, that (I) (we) last saw the deceased alive on 10-27-67 , 19, and that death occurred at 11:20 AM , from causes and on the date stated above.										
22a. SIGNATURE <i>Dr. Antonius Glahn</i> M.D.					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			22b. DATE SIGNED 10-27-67		
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.					22d. ADDRESS Springfield State Hospital Sykesville, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-30-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion			23d. LOCATION (City or Town) (County) (State) Carlisle Pa.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.					25a. REC'D BY REGISTRAR 4905 York Rd., Baltimore		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

OCT 30 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13716		CERTIFICATE OF DEATH	
13719			
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 31yrs. 6mos. 27dys.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore County c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Unknown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS Unknown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CAMILLA (NMN) LINDERMAN		4. DATE OF DEATH Month Day Year OCTOBER 6 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1884? 9. AGE (In years last birthday) yrs. 83? IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Address Records, Springfield State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) 4221 DUE TO (c) Moderately advanced pulmonary tuberculosis, probably inactive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0022		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-9-36 , 10-6-67 , 19__, that (I) (we) last saw the deceased alive on 10-6-67 19__, and that death occurred on 10-6-67 at 1:55 PM , from causes on and on the date stated above.			
22a. SIGNATURE Julian Radzykewycz, M.D.		22b. DATE SIGNED 10-6-67	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removed		23b. DATE THEREOF 10-9-67	
23c. NAME OF CEMETERY OR PREMATORY St. Mary's Cemetery		23d. LOCATION (City or Town) (County) (State) BALTIMORE, Md.	
24. FUNERAL DIRECTOR Frank J. Newell, Baltimore, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE OCT 10 1967	

13715

REMARKS ON DEATH

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REMARKS ON DEATH

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13717

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville		c. LENGTH OF STAY IN 1b 46 yrs 10 mo	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 731 E. 22nd Street	
3. NAME OF DECEASED (Type or print) Edward Joseph Lynch		4. DATE OF DEATH Month 10 Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12 - 15 - 1884
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 11 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Brakeman		10b. KIND OF BUSINESS OR INDUSTRY Rail Road	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Martin J. Lynch		14. MOTHER'S MAIDEN NAME Mary Shannahan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 220-54-9129	
17. INFORMANT Springfield Hospital records, Sykesville		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO (b) Old extensive myocardial infarction DUE TO (c) Bilateral bronchopneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. INTERVAL BETWEEN ONSET AND DEATH weeks Years Days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Schizophrenic Reaction, Hebephrenic type.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 1 (this hospital) attended the deceased from Dec 15 , 19 19 , to 10-14- , 1967, that 1 (we) last saw the deceased alive on 10-14- , 1967, and that death occurred at 10:45 PM from causes and on the date stated above.			
22a. SIGNATURE Octavio Ruiz		22b. DATE SIGNED 10-15-67	
22c. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D.		22d. ADDRESS Springfield State Hospital Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/18/67	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.	23d. LOCATION (City or Town) (County) (State) 3310 Taylor-Ave Md.
24. FUNERAL DIRECTOR John J. Cowanston Inc. 9 Hollins St.		25a. REC'D BY REGISTRAR OCT 17 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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13721

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PMS-Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Westminster		c. LENGTH OF STAY IN 1b ?	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 110 N. Calhoun Street	
3. NAME OF DECEASED (Type or print) First Middle Last HARVEY B. MARING		4. DATE OF DEATH Month Day Year 10-18-67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 29, 1935
9. AGE (In years lost birthday) yrs. 32		10. IF UNDER 1 YEAR Months Days Hours Min. 10-18-67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Carroll Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ralph D. Maring		14. MOTHER'S MAIDEN NAME Bessie W. Pickett	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes 1955 to 1957		16. SOCIAL SECURITY NO. 218-32-9076	
17. INFORMANT Mr. Ralph D. Maring Westminster, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound Skull (Shotgun) self inflicted DUE TO (b) DUE TO (c) 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) apparently placed gun at it & pulled trigger	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 10-18-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work Roadside	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) Carroll Md		20f. (City or town) (County) (State) CARROLL Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher		22. DATE SIGNED 10-18-67	
EXAMINER'S NAME (Type) W. Glenn Speicher		DEPUTY MEDICAL EXAMINER 135 Winchester Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/21/1967	
23c. NAME OF CEMETERY Winfield Church Of God		23d. LOCATION (City or Town) (County) (State) Carroll Co., Md.	
24. FUNERAL DIRECTOR C. M. Waltz Box 241 Sykesville, Md.		25a. REC'D BY REGISTRAR OCT 23 1967	
		25b. REGISTRAR'S SIGNATURE William Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13719

CERTIFICATE OF DEATH

13722

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural - Sykesville			c. LENGTH OF STAY IN 1b 4 mos. 23 da.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS 39 Maryland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILBUR Middle HARRISON Last MARTIN				4. DATE OF DEATH Month 10 - Day 9 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-1879		9. AGE (In years last birthday) 88 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unknown			10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown			16. SOCIAL SECURITY NO. 214-18-1688		17. INFORMANT Address Records, Springfield State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with senile brain disease with psychotic reaction.							INTERVAL BETWEEN ONSET AND DEATH years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from May 16, 19 67 to October 9, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 9, 19 67 , and that death occurred 11:20AM from causes and on the date stated above.							
22a. SIGNATURE <i>Julian Radzykewycz</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-9-67	
22c. PHYSICIAN'S NAME (Type) Julian Radzykewycz, M.D.				22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-21-67		23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.	
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.				25a. REC'D BY REGISTRAR DATE OCT 23 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 3yrs.25dys.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1104 W. 40th St.	
3. NAME OF DECEASED (Type or print) JOSEPH V. MINITOR		4. DATE OF DEATH Month OCTOBER Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-22-1899
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None Chauffeur	
10b. KIND OF BUSINESS OR INDUSTRY Sun Cab Company		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Unknown- Michael Minitor	
14. MOTHER'S MAIDEN NAME Unknown Cress		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown	
16. SOCIAL SECURITY NO. 213-10-2657-A		17. INFORMANT Records, Springfield State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Infected gangrenous decubitus ulcers		INTERVAL BETWEEN ONSET AND DEATH Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, with psychotic reaction		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 9-30-64 , to 10-25-67 , 19____, that (I) (we) last saw the deceased alive on 10-25-67 19____, and that death occurred at 6:35 AM from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 10-25-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 10-28-67	23c. NAME OF CEMETERY OR CREMATORY Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR Frank H. Seitz		25a. REC'D BY REGISTRAR 814 N 36th St. Balto City Md.	25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13721 CERTIFICATE OF DEATH 13721

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY in 1b <u>1 Month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		d. STREET ADDRESS <u>Day Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Carroll Co. Gen. Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>Annie</u> Last <u>Noyes</u>		4. DATE OF DEATH Month <u>10</u> Day <u>14</u> Year <u>1967</u>					
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-13-1896</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u>13</u> Min. <u>2</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Markley</u>		14. MOTHER'S MAIDEN NAME <u>Augusta Quarengesser</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Mr. Harvey Noyes - Sykesville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL VASCULAR INSUFFICIENCY</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>CEREBRAL THROMBOSIS</u> DUE TO (c) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH <u>IMMED.</u> <u>6 WKS.</u> <u>YEARS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>a.m.</u> Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8/31</u> , 19 <u>67</u> , to <u>10/14</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/14</u> , 19 <u>67</u> , and that death occurred at <u>6:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Vincent J. Firico Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/14/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Vincent J. Firico Jr.</u>				22d. ADDRESS <u>Westminster, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-17-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LAKE VIEW CEMETERY</u>	23d. LOCATION (City, town or county) <u>Sykesville, Md.</u>		(State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry W. Haight</u>			ADDRESS <u>Sykesville, Md.</u>		25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Johnas Judge</u>	

1937

CERTIFICATE OF DEATH

1937

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. Some words like "Name", "Age", "Sex", "Cause of Death" are faintly visible.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1
4
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13722

CERTIFICATE OF DEATH

13725

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Carroll</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>		c. LENGTH OF STAY IN Ib <u>15 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Sykesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gaither Road</u>			d. STREET ADDRESS <u>Gaither Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Clara Louise Peiffer</u>			4. DATE OF DEATH Month <u>Oct.</u> Day <u>1</u> Year <u>1967</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-1899</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Ill.</u>	
13. FATHER'S NAME <u>Oscar Sperber</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>-----</u>		
17. INFORMANT <u>Mr. Webb Peiffer</u>			Address <u>Sykesville, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL HEMORRHAGE</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO (c) <u>ARTERIOSCLEROTIC HEART DISEASE</u>					INTERVAL BETWEEN ONSET AND DEATH <u>few min.</u> <u>20 yrs</u> <u>20+yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) did not attended the deceased from <u>7/April/68</u> , 19 <u>68</u> , to <u>1/Oct/67</u> , 19 <u>67</u> , that (I) had saw the deceased alive on <u>1/Oct/67</u> , 19 <u>67</u> , and that death occurred at <u>7:30AM</u> from causes and on the date stated above					
22a. SIGNATURE <u>Wm. H. Lawson, Jr.</u>			22b. DATE SIGNED <u>1/Oct/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Wm. H. Lawson, Jr., M. D.</u>			22d. ADDRESS <u>Box 54, RD #2, Sykesville, Md. 21784</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>10-4-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Springfield Cemetery</u>		23d. LOCATION (City or Town) <u>Sykesville</u>	(County) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Harry W. Haight</u>			25a. REC'D BY REGISTRAR <u>OCT 9 1967</u>		
25b. REGISTRAR'S SIGNATURE <u>gcharles judge</u>					

3472

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove capers, papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13722

13726

1. PLACE OF DEATH a. COUNTY <u>CARROLL CO.</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> c. LENGTH OF STAY IN TB <u>1 MO. +</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL CO. GEN. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u> d. STREET ADDRESS <u>30 PARK AVE.</u> a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HERBERT MELVIN PHILLIPS</u>		4. DATE OF DEATH Month <u>OCT.</u> Day <u>3</u> Year <u>1967</u>					
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 4, 1894</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SCHOOL BUS OWNER AND DRIVER</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME <u>JAMES ALFRED PHILLIPS</u>			14. MOTHER'S MAIDEN NAME <u>ALMIRA FISHER</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes give year or dates of service) <u></u>			16. SOCIAL SECURITY NO. <u>219-14-9527A</u>		17. INFORMANT Address <u>SAME</u> <u>MRS. ETHEL S. PHILLIPS ADDRESS</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour <u></u> e.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1963</u> to <u>Oct. 3, 1967</u> , that (I) (we) last saw the deceased alive on <u>Oct 3, 1967</u> , and that death occurred at <u>10:55 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John S. Harshey</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN S. HARSHEY, M.D.</u>				22d. ADDRESS <u>8 Archer St. Westminster, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>OCT. 6, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WESTMINSTER CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>WESTMINSTER MD</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers, Jr., Westminster, Md</u>				25a. REC'D BY REGISTRAR <u>OCT 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

29781

Antennaria plantaginifolia

13724

CERTIFICATE OF DEATH

13727

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 10 mos. 7 yrs. 14 days. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 514 E. Pratt St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH (NMN) REINFELTS		4. DATE OF DEATH Month Day Year OCTOBER 4 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-1890 9. AGE (In years last birthday) yrs. 77
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Porter (retired)		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Reinfelts		14. MOTHER'S MAIDEN NAME Birdie Killmayer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-12-7425	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO (b) Pulmonary emphysema DUE TO (c) Old, arrested pulmonary tuberculosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Old, 2		INTERVAL BETWEEN ONSET AND DEATH Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with other CNS syphilis, without qualifying phrase Old, arrested pulmonary tuberculosis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11-20-59 , 19____, to 10-4-67 , 19____, that (I) (we) last saw the deceased alive on 10-4-67 , 19____, and that death occurred at 11:15 AM , from causes and on the date stated above.			
22a. SIGNATURE Octavio A. Ruiz		22b. DATE SIGNED 10-5-67	
22c. PHYSICIAN'S NAME (Type) Octavio A. Ruiz, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/7/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR DATE OCT 9 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 2mos. 28dys.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport		d. STREET ADDRESS 111 Main St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BERNICE OPHELIA REPP		4. DATE OF DEATH Month OCTOBER Day 31 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-16-1894
9. AGE (In years lost birthday) yrs. 73		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher	
11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Philip Sherman Carnell		14. MOTHER'S MAIDEN NAME Rebecca Florence Dermitt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-52-0276	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CBS assoc. with cerebral arteriosclerosis, with neurotic reaction		INTERVAL BETWEEN ONSET AND DEATH Weeks Years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-3-67 , 19____, to 10-31-67 , 19____, that (I) (we) last saw the deceased alive on 10-31-67 , 19____, and that death occurred at 10:25 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Antonius Glahn</i>		22b. DATE SIGNED 11-1-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 4, 1967	
23c. NAME OF CEMETERY OR CREMATORY Philos Cemetery		23d. LOCATION (City or Town) (County) (State) Westernport Alleg. Md	
24. FUNERAL DIRECTOR W. Harold Fredlock Piedmont, W.Va.		25a. REC'D BY REGISTRAR NOV 3 1967	
25b. REGISTRAR'S SIGNATURE <i>John Judge</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
13726 CERTIFICATE OF DEATH 13729									
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 30-4				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md.			c. LENGTH OF STAY IN 1b 3 Yrs. 4 Mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21229				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					d. STREET ADDRESS 4649 Rokeby Rd.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Theodore Anthony Rettaliata First Middle Last					4. DATE OF DEATH Oct 8, 1967 Month Day Year				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-1-86		9. AGE (In years lost birthday) 80 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John J. Rettaliata				14. MOTHER'S MAIDEN NAME Julia V.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-01-4551		17. INFORMANT Hospital Records Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced Generalized arteriosclerosis 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO (a) _____ (b) _____ (c) _____								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-2- , 19 64 , to 10-8- , 19 67 , that (I) (we) last saw the deceased alive on 10-8-67 , 19 67 , and that death occurred at 1 P.M. from causes and on the date stated above.									
22a. SIGNATURE Orlando C. Ramos				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 10-8-67	
22c. PHYSICIAN'S NAME (Type) Orlando C. Ramos				22d. ADDRESS Springfield state hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/10/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Wm. Fickner Sons				ADDRESS Baltimore, Md.		25a. REC'D BY REGISTRAR Oct 11 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove, carbon, papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13730

13727

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN 1b 6 yrs. 5 mos. 8 dys. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) CAROLINE VIRGINIA RHODES			4. DATE OF DEATH Month Day Year OCTOBER 5 19 67		
5. SEX Female	6. COLOR OR RACE /White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-10-1888	9. AGE (In years last birthday) 79 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 5 19 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Raymond E. Rhodes		
14. MOTHER'S MAIDEN NAME Josephine V. Johnson			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		
16. SOCIAL SECURITY NO. Unk.			17. INFORMANT Address Records, Springfield State Hospital		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO (b) Generalized arteriosclerosis DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH Years Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with senile brain disease, with psychotic reaction					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 4-27-61 , 19 61 , to 10-5-67 , 19 67 , that (I) (we) last saw the deceased alive on 10-5-67 , 19 67 , and that death occurred at 5:00 P. from causes and on the date stated above.					
22a. SIGNATURE Antonius Glahn M.D.			22b. DATE SIGNED 10-5-67		
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M. D.			22d. ADDRESS Springfield State Hospital, Sykesville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)		
BURIAL	10-14-67	Freedom Cemetery	Sykesville, Md		
24. FUNERAL DIRECTOR Harry W. Haight			25a. REC'D BY REGISTRAR OCT 17 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove (or tear) papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13728

CERTIFICATE OF DEATH

13731

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 19 yrs. 3 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 3032 Boston St.	
3. NAME OF DECEASED (Type or print) SOPHIE FRANCES SAKOWICZ		4. DATE OF DEATH Month Day Year OCTOBER 14 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Sep. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-14
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Worker		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Anthony Sakowicz		14. MOTHER'S MAIDEN NAME Angeline Noyai	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-09-8005	
17. INFORMANT Records, Springfield State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Extensive bilateral bronchopneumonia DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Schizophrenic reaction, paranoid type		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-14-48 , 19__ to 10-14-67 , 19__, that (I) (we) last saw the deceased alive on 10-14-67 , 19__, and that death occurred at 11:30 AM from causes on and on the date stated above.			
22a. SIGNATURE Antonius Glahn, M.D.		22b. DATE SIGNED 10-18-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-20-67	
23c. NAME OF CEMETERY OR CREMATORY Freedom Cemetery		23d. LOCATION (City or Town) (County) (State) Sykesville Md.	
24. FUNERAL DIRECTOR Harry W. Haight		25a. REC'D BY REGISTRAR Sykesville, Md.	
25b. REGISTRAR'S SIGNATURE Oct 22 1967		DATE Oct 22 1967	

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STATE OF TEXAS

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COUNTY OF DALLAS

WARRANT

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13729

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville c. LENGTH OF STAY IN lb 6 months		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SOPHIA CATHERINE SAUER		4. DATE OF DEATH Month 10 - Day 26 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7 - 28 - 80
9. AGE (In years last birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME George L. Bents (dec.)	
14. MOTHER'S MAIDEN NAME unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 214-20-9333		17. INFORMANT Hospital Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Generalized Arteriosclerotic Cardio-vascular Disease DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 5 - 8 , 19 67 to 10 - 26 , 19 67 that (I) (we) last saw the deceased alive on 10 - 26 , 19 67 , and that death occurred at 10:PM , from causes and on the date stated above			
22a. SIGNATURE D'Alfredo M. Labrit		22b. DATE SIGNED 10-26-67	
22c. PHYSICIAN'S NAME (Type) D'Alfredo M. Labrit		22d. ADDRESS Springfield State Hospital	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10-30-1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR'S ADDRESS G. Howard Strong 3207 W. North Ave.,		25a. REC'D BY REGISTRAR OCT 30 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

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Name of Deceased		Date of Birth		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
John Doe		10-10-1900		Male		White		Married		Farmer		Heart Disease		Home		10-20-47		10:00 AM		J. Smith		A. Jones	
Place of Birth		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
New York		10-20-47		Male		White		Married		Farmer		Heart Disease		Home		10-20-47		10:00 AM		J. Smith		A. Jones	
Age at Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
47		10-20-47		Male		White		Married		Farmer		Heart Disease		Home		10-20-47		10:00 AM		J. Smith		A. Jones	
Date of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
10-20-47		10-20-47		Male		White		Married		Farmer		Heart Disease		Home		10-20-47		10:00 AM		J. Smith		A. Jones	
Time of Death		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
10:00 AM		10-20-47		Male		White		Married		Farmer		Heart Disease		Home		10-20-47		10:00 AM		J. Smith		A. Jones	
Signature of Physician		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
J. Smith		10-20-47		Male		White		Married		Farmer		Heart Disease		Home		10-20-47		10:00 AM		J. Smith		A. Jones	
Signature of Registrar		Date of Death		Sex		Race		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Physician		Signature of Registrar	
A. Jones		10-20-47		Male		White		Married		Farmer		Heart Disease		Home		10-20-47		10:00 AM		J. Smith		A. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13730		13733	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville,		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 30-4 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21230	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ruth Elaine SCHWABLINE		4. DATE OF DEATH Month October Day 21 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-13-23
9. AGE (In years last birthday) 44 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Earl Schwabline		14. MOTHER'S MAIDEN NAME Atlantic Jones	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Springfield State Hospital Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) CBS with congenital spastic paraplegia without qualifying phrase. Mental retardation, severe.		INTERVAL BETWEEN ONSET AND DEATH days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-5-43 , 19__ to 10-21-67 , 19__, that (I) (we) last saw the deceased alive on 10-21-67 , 19__, and that death occurred at 4:25 p.m. from causes and on the date stated above.			
22a. SIGNATURE <i>Dr. Antonius Glahn</i>		22b. DATE SIGNED 10-21-67	
22c. PHYSICIAN'S NAME (Type) Antonius Glahn, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland 21784	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10 23 67	
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Brooklyn, A. A. Co. Md.	
24. FUNERAL DIRECTOR Mc Cully		25a. REC'D BY REGISTRAR OCT 23 1967	
ADDRESS 130 E. Fort Ave.		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

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UNION OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician. Page 2 must be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13731											
1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				c. LENGTH OF STAY IN 1b <u>45 YRS.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>				d. STREET ADDRESS <u>17 CHASE ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>CARROLL G. GEN. HOSPITAL</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES LEWIS SEIPP SR.</u>						4. DATE OF DEATH Month Day Year <u>10 15 1967</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>DEC. 11, 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POLICEMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>CITY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>CARROLL Co. MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>LEWIS SEIPP</u>						14. MOTHER'S MAIDEN NAME <u>ROSIN DRECHSLER</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes give war or dates of service) <u>WWI</u>				16. SOCIAL SECURITY NO. <u>215-34-1073</u>		17. INFORMANT Address <u>17 CHASE ST.</u> <u>MRS. MELVIN I. BLIZZARD, WESTMINSTER, MD.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>MYOCARDIAL INFARCTION</u> (c) <u>HYPERTENSIVE ARTERIO SCLEROTIC DISEASE</u> HEART PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) INTERVAL BETWEEN ONSET AND DEATH <u>IMMED.</u> <u>12 DAYS</u> <u>YEARS</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>10/3</u> , 19 <u>67</u> , to <u>10/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>10/15</u> , 19 <u>67</u> , and that death occurred at <u>12:35</u> PM, from the causes and on the date stated above.											
22a. SIGNATURE <u>Vincent J. Kroca Jr</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>10/15/67</u>			
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>10/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KRIDERS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>RURAL, WESTMINSTER MD</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Myers Jr, Westminster, Md.</u>						25a. REC'D BY REGISTRAR <u>OCT 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

1. *Journal of the American Medical Association*, 1997; 277: 1033-1037.

1992

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13732

13735

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Ohio b. COUNTY Alleg. Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 1mo 26da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		e. STREET ADDRESS 1421 W. 84th Street	
3. NAME OF DECEASED (Type or print) Harry Allen Shaffer		4. DATE OF DEATH Month October Day 15 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-2-27
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		11. BIRTHPLACE (State or foreign country) Illinois	
13. FATHER'S NAME Harry Shaffer		14. MOTHER'S MAIDEN NAME Edna Keeler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 312-22-0662	
17. INFORMANT Springfield State Hosp. Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO Massive Pulmonary Emboli DUE TO Commuted fracture distal end of tibia and fibula left.		INTERVAL BETWEEN ONSET AND DEATH Sudden 9-12-67	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped out sleeping room window	
20c. TIME OF INJURY Month, Day, Year Hour 10:00 p.m. 9/12 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) HOSPITAL		20f. (City or town) (County) (State) Sykesville Carroll Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. Glenn Speicher M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) W. Glenn Speicher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-19-67	
23c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery		23d. LOCATION (City or town) (County) (State) WESTMINSTER CARROLL	
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.		25a. REC'D BY REGISTRAR OCT 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge		22. DATE SIGNED 10-15-67	

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13738

CERTIFICATE OF DEATH

13736

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled-in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1 HERSH AVE				d. STREET ADDRESS 1 HERSH AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ALLIE Middle I Last SHERFEY				4. DATE OF DEATH Month OCT Day 17 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV 24-1886	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD HAHN				14. MOTHER'S MAIDEN NAME ANNA EARLY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-03-5848		17. INFORMANT Address JOHN SHERFEY WESTMINSTER MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 10 , 19 67 , to Oct 17 , 19 67 , that (I) (we) last saw the deceased alive on Oct 17 , 19 67 , and that death occurred at 4:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Julius Chepko				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 10/19/67	
22c. PHYSICIAN'S NAME (Type) Julius Chepko				22d. ADDRESS 85 1/2 W. Green St Westminister Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT 20-1967		23c. NAME OF CEMETERY OR CREMATORY MT HOPE		23d. LOCATION (City or Town) (County) (State) WOODSBORO MD	
24. FUNERAL DIRECTOR D. Hartzler & Sons New Windsor				25a. REC'D BY REGISTRAR DATE OCT 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1992

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13734

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13737

1. PLACE OF DEATH a. COUNTY CARROLL CO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER		c. LENGTH OF STAY IN 1b MINUETS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CARROLL CO. GEN. HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) GLADYS B. SLASMAN		4. DATE OF DEATH Month 10 - Day 9 - Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC 5, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTROL SUPPLY		10b. KIND OF BUSINESS OR INDUSTRY HOSPITAL	9. AGE (In years last birthday) 52 yrs.
11. BIRTHPLACE (State or foreign country) WASHINGTON, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PURCELL CARRICK		14. MOTHER'S MAIDEN NAME GERTRUDE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 212-52-9511		16. SOCIAL SECURITY NO. 212-52-9511	
17. INFORMANT MR. J. HOWARD SLASMAN		Address FINKSBURG, RT#2 MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 8234 IMMEDIATE CAUSE (a) Fracture Base Skull DUE TO (b) 4 other Multiple Fractures stating the underlying cause last. (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 1 hr 25 min
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) car Ran off Road struck a Tree			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) car Ran off Road struck a Tree	
20c. TIME OF INJURY Month, Day, Year 6:55 a.m. 10-9-67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) Carroll		20f. (City or town) (County) (State) Westminster Carroll Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE W. H. Speicher		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, P.O. box, or agency) 138 E. Main St	
EXAMINER'S NAME (Type) W. H. Speicher		22. DATE SIGNED 10-9-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 10/12/67	23c. NAME OF CEMETERY OR CREMATORY PROVIDENCE CEM. MD.	23d. LOCATION (City or Town) (County) (State) Westminster Carroll Md
24. FUNERAL DIRECTOR J. S. Myers, Jr. Westminster, Md. 21157		25a. REC'D BY REGISTRAR OCT 11 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13735
CERTIFICATE OF DEATH
13738

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Adams			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural, Westminster				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 40 Lumber St., Littlestown, Pa.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Meadow View Convalescent Home Westminster, Md. R. D. 1				d. STREET ADDRESS 40 Lumber Street			
3. NAME OF DECEASED (Type or print) First Rffie Middle Blanche Last Smith				4. DATE OF DEATH Month October Day 3 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/2/1891	
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Housework				10b. KIND OF BUSINESS OR INDUSTRY Her own home.		11. BIRTHPLACE (County & State, or foreign country) Adams County, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John J. Sanders				14. MOTHER'S MAIDEN NAME Annie Watson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 166-12-4295		17. INFORMANT Mrs. P. K. Hymiller,	
				Address 314 S. Queen St.		Littlestown, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Hypertensive Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 min 15 YRS							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from JUNE 21, 1957 to OCT. 3, 1967 , that (I) (we) last saw the deceased alive on SEPT. 18, 1967 , and that death occurred at 5:40 AM , from the causes and on the date stated above.							
22a. SIGNATURE L. L. Potter M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED OCT 4, 1967	
22c. PHYSICIAN'S NAME (Type) L. L. POTTER M.D.				22d. ADDRESS LITTLESTOWN, PA.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10/6/67		23c. NAME OF CEMETERY OR CREMATORY St. Aloysius Cemetery		23d. LOCATION (City, town or county) (State) Littlestown, Adams Co., Pa.	
24. FUNERAL DIRECTOR Richard A. Little				ADDRESS Littlestown, PA.		25a. REC'D BY REGISTRAR Charles Judge	
				25b. REGISTRAR'S SIGNATURE			

1373

Carroll

Thompson

Adams

James, Westchester

at Morris

40 James St., Littleton, Pa.

William Westchester Home

40 James St.

Littleton, Pa.

Miss

James

Smith

October

1914

Littleton, Pa.

x

10/1/1914

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James, Westchester

James, Westchester

John J. James

James, Westchester

10-1-1914

James, Westchester

10-1-1914

Littleton, Pa.



James

10/1/1914

Littleton, Pa.

10-1-1914

13736

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13739

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u>		c. LENGTH OF STAY IN 1b <u>8 Days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll County General Hospital</u>		e. STREET ADDRESS <u>111 Summit, Ave</u>	
3. NAME OF DECEASED (Type or print) <u>BLANCHE C. SNYDER</u>		4. DATE OF DEATH Month <u>10</u> - Day <u>27</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 18, 1902</u>
9. AGE (In years last birthday) yrs. <u>64</u>		IF UNDER 1 YEAR Months <u>10</u> Days <u>27</u> Hours <u>19</u> Min. <u>67</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House-wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Lowell, Mass</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John C. Cook</u>		14. MOTHER'S MAIDEN NAME <u>Mary B. Thurston</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-12-1061</u>	
17. INFORMANT <u>Varnan A. Snyder</u>		Address <u>111 Summit, Ave. Hampstead, Md. 21074</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus Bilateral (acute)</u> DUE TO <u>Fractured R. Humerus open Reduct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>+ Immobilization of arm</u> (b) <u>10-5-67</u> (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10-5-67</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell down steps at home landed on left knee</u>	
20c. TIME OF INJURY Month, Day, Year <u>1:30 p.m. 10-2 1967</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hampstead Carroll Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>W. Glenn Speicher</u> M.D.		22. DATE SIGNED <u>10-27-67</u>	
EXAMINER'S NAME (Type) <u>W. Glenn Speicher</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1358 Marie Westminster Carroll</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>10/31/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hampstead Carroll Md.</u>	
24. FUNERAL DIRECTOR <u>John E. Goff</u>		25a. REC'D BY REGISTRAR <u>OCT 31 1967</u>	
ADDRESS <u>Hampstead, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13737

13740

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS 3518 Ingleside Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) XXXXXXXXXX First MOLLY Middle NMN Last SOLOWESZYK			4. DATE OF DEATH Month 10 Day 26 Year 19 67		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9-18-14		9. AGE (In years last birthday) 53 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) Poland	
12. CITIZEN OF WHAT COUNTRY? U. S. A.			13. FATHER'S NAME XXXXXXXXXX DAVID REICHENBERG		
14. MOTHER'S MAIDEN NAME XXXXXXXXXX ANNA RAPPAPORT			15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		
16. SOCIAL SECURITY NO. unknown			17. INFORMANT MR. PINKUS SOLOWESZYK, 3518 INGLESIDE AVE. #15 SPRINGFIELD STATE HOSP.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Portal Cirrhosis OUE TO Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) OUE TO (c)					
PART II. OTHER SIGNIFICANT CONOITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 10-24, 19 67, to 10-26, 19 67 that (I) (we) last saw the deceased alive on 10-26 19 67, and that death occurred at 10:10 PM, from causes and on the date stated above					
22a. SIGNATURE D'Alfredo M. Labrit			22b. DATE SIGNED 10-26-67		22c. PHYSICIAN'S NAME (Type) D'Alfredo M. Labrit
22d. ADDRESS Springfield State Hospital			22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-29-67		23c. NAME OF CEMETERY OR CREMATORY CHOFETZ HEBREW MT. CARMEL CHAIM	
23d. LOCATION (City or Town) BALTIMORE, MARYLAND		23e. REGISTRAR'S SIGNATURE Charles Judge			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REISTERSTOWN ROAD		24a. ADDRESS		24b. REC'D BY REGISTRAR DATE NOV 6 1967	

MEDICAL CERTIFICATION

1-10-41

CHIEF OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13738

CERTIFICATE OF DEATH

13741

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 42 yr 5 mo 15	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) da. unknown		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital			d. STREET ADDRESS -----		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILBUR Middle BRUCE Last SPEAKE			4. DATE OF DEATH Month 10/ Day 25 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/2/98		9. AGE (In years last birthday) 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (County & State, or foreign country) Frederick County		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Calvin I. Speake			14. MOTHER'S MAIDEN NAME Emma Jane Derr		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	17. INFORMANT Address Springfield State Hospital Records		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Uremia DUE TO (c) Generalized arteriosclerosis, Art. cardiovascular disease yrs.					INTERVAL BETWEEN ONSET AND DEATH days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CBS assoc. with convulsive disorder without qualifying phrase					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/10/25 , 19 67 , to 10/25/ , 19 67 , that (I) (we) last saw the deceased alive on 10/25/ , 19 67 , and that death occurred at 7:35 AM , from causes and on the date stated above.					
22a. SIGNATURE Suha Ozgun.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/25/67
22c. PHYSICIAN'S NAME (Type) Suha Ozgun, M. D.			22d. ADDRESS Springfield State Hospital		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/28/67	23c. NAME OF CEMETERY OR CREMATORY St. Johns Cemetery	23d. LOCATION (City or Town) (County) (State) Creagerstown, Fred., Md.		
24. FUNERAL DIRECTOR W. C. Barton		ADDRESS W. C. Barton		25a. REC'D BY REGISTRAR OCT 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

13734

CERTIFICATE OF DEATH

13734

Deceased

Name

Deceased

Age

Sex

Color

Place of Birth

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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13743

FOR STATE
HEALTH DEPT.

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M 13739

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville				c. LENGTH OF STAY in lb Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Railroad Yard, Sykesville, Md.				d. STREET ADDRESS Sykesville, Maryland			
3. NAME OF DECEASED (Type or print) BENJAMIN PEYTON SULLIVAN				4. DATE OF DEATH October 29 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1917		9. AGE (In years lost birthday) yrs. 49		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Food		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Emma Clark			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes U.W. II		16. SOCIAL SECURITY NO. ?		17. INFORMANT Mrs. Helen Duval - Sykesville Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 4221 DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Edward F. Wilson				22. DATE SIGNED October 30, 1967			
EXAMINER'S NAME (Type) Edward F. Wilson, M.D.				22. DATE SIGNED October 30, 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11-1-67		23c. NAME OF CEMETERY OR CREMATORY BALTO NATIONAL		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Harry W. Haight				25a. REC'D BY REGISTRAR NOV 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician. Page 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13740

13744

1. PLACE OF DEATH a. COUNTY CARROLL CO. b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER c. LENGTH OF STAY IN 1b 3 WEEKS + d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) CARROLL CO. GENERAL HOSPITAL (FRIZELLSBURG)			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WESTMINSTER, RT# 7 d. STREET ADDRESS 06-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last WINFIELD SCOTT SULLIVAN			4. DATE OF DEATH Month Day Year OCT. 24 1967		
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH OCT. 8, 1886		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 MRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR, FLOUR MILL AND DAIRY		10b. KIND OF BUSINESS OR INDUSTRY CARROLL CO.		11. BIRTHPLACE (County & State, or foreign country) PLEASANT VALLEY MD.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME ISAAC N. SULLIVAN		14. MOTHER'S MAIDEN NAME MARY JANE TOWNSEND	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-01-874		17. INFORMANT Address MRS W. SCOTT SULLIVAN, WESTMINSTER MD. RT# 7	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of the pancreas (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH					
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 9/29 , 19 67 , to 10/24 , 19 67 , that (I) (we) last saw the deceased alive on 10/24 , 19 67 , and that death occurred at 8:15 A.M., from the causes and on the date stated above.					
22a. SIGNATURE John S. Harshey M.D.			22b. DATE SIGNED 10/24/67		
22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.			22d. ADDRESS 8 Anchor St Westminster, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10/27/67		23c. NAME OF CEMETERY OR CREMATORY MEADOW BRANCH CEMETERY, WESTMINSTER, MD.	
23d. LOCATION (City, town or county) (State) RURAL		24. FUNERAL DIRECTOR'S SIGNATURE J.E. Myers, Jr., Westminster, Md. ADDRESS DATE OCT 31 1967			
25a. REC'D BY REGISTRAR J Charles Judge		25b. REGISTRAR'S SIGNATURE J Charles Judge			

2. Proprietor, Westminster, Md. Oct 11 1881

10/27/81 Menden Hall & Cemetery Westminster, Md.

John S. Harkney, no. 214 at Westminster, Md.

John S. Harkney

10/27/81 10/27/81 10/27/81

General Agent

215-CI-814 Mrs. H. Scott Sullivan Westminster, Md.

Mary Jane Townsend

Operator Four Mile and Dairy Pleasant Valley Rd. N. 2. A.

Marc White Oct 8 1881

Winfield Scott Sullivan Oct 24 81

Carroll Co. General Hospital (Pittsburg)

Westminster Sheet + Westminster Rtn 7

Carroll Co. Maryland

10/27/81

CERTIFICATE OF DEATH

13745

13741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balt.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Sykesville</u>		c. LENGTH OF STAY IN 1b <u>3m, 11d.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		e. STREET ADDRESS <u>3808 old York Road</u>	
3. NAME OF DECEASED (Type of print) First <u>Wilson</u> Middle <u>Bowman</u> Last <u>Swain</u>		4. DATE OF DEATH Month <u>10</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-9-92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Druggist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>344-09-1224</u>	9. AGE (In years last birthday) yrs. <u>74</u>
11. BIRTHPLACE (County & State, or foreign country) <u>New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson Swain</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>344-09-1224</u>	
17. INFORMANT <u>Springfield Hospital records - Sykesville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>6-27-</u> , 19 <u>67</u> , to <u>10-7</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at _____ M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Mario E. Comas</u>		22b. DATE SIGNED <u>10/8/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>MARIO E. COMAS M.D.</u>		22d. ADDRESS <u>1302 KENSEL CT. Balt. Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>10/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Freeland Balto. Md.</u>
24. FUNERAL DIRECTOR <u>Isaac Harstenstein</u>		25a. REC'D BY REGISTRAR <u>OCT 11 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles J. Jager</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
13742		13746	
CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville		c. LENGTH OF STAY IN 1b 14yrs.6mo.9days c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital		d. STREET ADDRESS 1411 Poplar Grove e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MINNIE First R. Middle TAYLOR Last		4. DATE OF DEATH Month October Day 25 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-16-84 9. AGE (In years last birthday) 83 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher		10b. KIND OF BUSINESS OR INDUSTRY ---	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Watson		14. MOTHER'S MAIDEN NAME Martha R. Coleman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-01-8855	
17. INFORMANT Records Address Sykesville, Maryland		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4341 IMMEDIATE CAUSE (a) Pneumonia DUE TO (b) Acute congestive heart failure. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Involuntional psychotic reaction.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-16, 1953 to 10-25, 1967 , that (I) (we) lost saw the deceased alive on 10-25, 1967 , and that death occurred at 5:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Irfan I Esendal M.D. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10-25-67	
22c. PHYSICIAN'S NAME (Type) Irfan, Esendal, M.D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/28/67	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cem.	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. Balto. Md.		25a. REC'D BY REGISTRAR DATE OCT 30 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

3258

45-11-100

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- 50 -

Page 10 of 10

TABLE 1. *Continued*

13742

CERTIFICATE OF DEATH

13747

1. PLACE OF DEATH a. COUNTY CARROLL MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CARROLL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG RT#2		c. LENGTH OF STAY IN 1b 1 YEAR 1/2	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FINKSBURG RT#2		d. STREET ADDRESS LAWNDALE ROAD	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) LAWNDALE ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Lilly MAY TROUT		4. DATE OF DEATH Month OCT. Day 10 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 6 1894
9. AGE (In years lost birthday) yrs. 73		10. IF UNDER 1 YEAR Months 1 Days 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE-WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) FREDERICK CO. MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN BYARD		14. MOTHER'S MAIDEN NAME JOSEPHINE WETZEL	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 213-26-0574	
17. INFORMANT MR. JAMES A. TROUT, FINKSBURG RT#2 MD		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Oedema DUE TO (b) Chronic Myocarditis DUE TO (c) Arterio-sclerosis - C-V. Disease		INTERVAL BETWEEN ONSET AND DEATH 1 hr. 10 yr. 10 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-30 , 19 59 , to 10-10 , 19 67 , that (II) (we) last saw the deceased alive on 10-10 19 67 , and that death occurred at 10:40 M, from causes on and on the date stated above.			
22a. SIGNATURE M.C. Porterfield		22b. DATE SIGNED 10-11-67	
22c. PHYSICIAN'S NAME (Type) M.C. Porterfield		22d. ADDRESS Hampstead, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF OCT. 13, 1967	
23c. NAME OF CEMETERY OR CREMATORY EVERGREEN MEM. GARDEN		23d. LOCATION (City or Town) (County) (State) FINKSBURG, CARROLL CO. MD	
24. FUNERAL DIRECTOR J.S. Myers, Jr., Westminster, Md.		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE MD		DATE OCT 16 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2581

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Carroll b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Westminster c. LENGTH OF STAY in lb MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Carroll County General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. COUNTY Baltimore g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore h. STREET ADDRESS 4132 Parkside Drive i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LULA M. UNGER		4. DATE OF DEATH Month October Day 24 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 3, 1908
9. AGE (In years last birthday) 59 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Beck	
14. MOTHER'S MAIDEN NAME Augusta Bettien		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. No		17. INFORMANT Elliott F. W. Unger, 4132 Parkside Drive	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 DUE TO Coronary Thrombosis Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO Atherosclerosis' Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 3 days 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 10/24 to 10/24 , 19 67 , that (I) (we) last saw the deceased alive on 10/24 , 19 67 , and that death occurred at 9:50 P.M. from the causes and on the date stated above.			
22a. SIGNATURE John S. Harshey 22c. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22b. DATE SIGNED 10/24/67 22d. ADDRESS 8 Ancho St Westminster Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 10/28/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Md.
24. FUNERAL DIRECTOR'S SIGNATURE Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR OCT 27 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13745

CERTIFICATE OF DEATH

13749

1. PLACE OF DEATH o. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. LENGTH OF STAY IN lb <u>3 months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long View Nursing Home Inc</u>		d. STREET ADDRESS <u>Route 2</u>	
3. NAME OF DECEASED (Type or print) First <u>Grace</u> Middle <u>L</u> Last <u>Warehime</u>		4. DATE OF DEATH Month <u>Oct</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 22, 1873</u>
9. AGE (In years last birthday) <u>94</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll County, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Benjamin Byers</u>	
14. MOTHER'S MAIDEN NAME <u>Caroline Stocksdate</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-46-4665</u>		17. INFORMANT Address <u>June Warehime, Box 169 Owings Mills, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>5 YRS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from <u>7/19</u> , 19 <u>67</u> , to <u>10/12</u> , 19 <u>67</u> , that (we) lost saw the deceased alive on <u>10/10</u> , 19 <u>67</u> , and that death occurred at <u>7:45 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>W. H. Foard</u>		22b. DATE SIGNED <u>10/12/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>		22d. ADDRESS <u>Manchester, Md 21102</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10/14/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MEADOW BRANCH CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>Westminster, Md.</u>	
24. FUNERAL DIRECTOR <u>J. S. Myers, Jr., Westminster, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>OCT 16 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1940

DEPARTMENT OF HEALTH

1940

For the purpose of this report, the following information was obtained from the records of the Department of Health, State of New York, for the year 1940.

The following table shows the number of cases of the disease reported for each month of the year 1940.

Month	Number of Cases
January	12
February	15
March	18
April	20
May	22
June	25
July	28
August	30
September	32
October	35
November	38
December	40

The total number of cases reported for the year 1940 was 350.

On 10/12/40, the following information was received from the records of the Department of Health, State of New York, for the year 1940.

The following table shows the number of cases of the disease reported for each month of the year 1940.

Month	Number of Cases
January	12
February	15
March	18
April	20
May	22
June	25
July	28
August	30
September	32
October	35
November	38
December	40

The total number of cases reported for the year 1940 was 350.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY Carroll MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sykesville, Md. c. LENGTH OF STAY IN 1b 2 Yrs. 5 Mo 14 da d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Lonaconing, Md. d. STREET ADDRESS Avilton area e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Eliza Katherine (Evans) Warnick			4. DATE OF DEATH 10-15 1967		5. SEX F		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Cotton Mill			10b. KIND OF BUSINESS OR INDUSTRY West Virginia		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA		8. DATE OF BIRTH 4-9-91		
13. FATHER'S NAME Peter Abraham Evans			14. MOTHER'S MAIDEN NAME Minty Schell			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 220-10-2932			17. INFORMANT Springfield Hospital Records Sykesville Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart failure 4201 CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. DUE TO (b) Coronary artery disease with old myocardial infarct. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH Weeks Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) CBS Assec. With Cerebral Art. with behavioral reaction										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (this hospital) attended the deceased from 4-16 , 19 65 , to 10-15 , 19 67 , that (we) last saw the deceased alive on 10-15 , 19 67 , and that death occurred at 11a M, from the causes and on the date stated above.		
22a. SIGNATURE 			22b. DATE SIGNED 10-16-67		22c. PHYSICIAN'S NAME (Type) Orlando Cabrera, M. D.		22d. ADDRESS Springfield State Hospital Sykesville, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 10/19/67		23c. NAME OF CEMETERY OR CREMATORY Nethken Hill Cemetery		23d. LOCATION (City, town or county) (State) Elk Garden, Mineral Co. W.V.		24. FUNERAL DIRECTOR Amy Michael Sharpless ADDRESS Blaine, W. Va. P.O. Kitzmiller, Md.		
25a. REC'D BY REGISTRAR OCT 19 1967			25b. REGISTRAR'S SIGNATURE 								

100-10-5232

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13747

13751

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>		c. LENGTH OF STAY IN 1b <u>39yrs. 6mos. 3wks.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Springfield State Hospital</u>		d. STREET ADDRESS <u>1410 Morling Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>GEORGE E. WEISE</u>		4. DATE OF DEATH <u>OCTOBER 22 19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-22-04</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Christian E. Weise</u>		14. MOTHER'S MAIDEN NAME <u>Cora Bald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-01-0972</u>	
17. INFORMANT <u>Records, Springfield State Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recent myocardial infarction</u> DUE TO (b) <u>Coronary artery thrombosis</u> DUE TO (c) <u>Bronchopneumonia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Weeks</u> <u>Weeks</u> <u>Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Manic depressive reaction, other</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-19-28</u> , 19 <u>67</u> , to <u>10-22-67</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>10-22-67</u> , 19 <u>67</u> , and that death occurred at <u>7:40 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Octavio A. Ruiz</u> M.D.		22b. DATE SIGNED <u>10-23-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Octavio A. Ruiz, M. D.</u>		22d. ADDRESS <u>Springfield State Hospital Sykesville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>10-25-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD</u>	
24. FUNERAL DIRECTOR <u>BURGEE FUNERAL HOME 3631 Falls Rd</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>William R. Kleiber</u>		25b. REGISTRAR'S SIGNATURE	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1-113-1-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (9)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13743

13752

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Carroll	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hampstead		c. LENGTH OF STAY IN 1b Hampstead	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 119 N. Main Street		d. STREET ADDRESS 119 N. Main Street	
3. NAME OF DECEASED (Type or print) THOMAS HARRISON WISNER		4. DATE OF DEATH Month 10 - Day 23 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 31, 1914
9. AGE (In years last birthday) yrs. 53		IF UNDER 1 YEAR Months 06 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William H. Wisner		14. MOTHER'S MAIDEN NAME Kathryn Hedrick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 212-16-0996	
17. INFORMANT Mrs. Edna E. Wisner		Address Hampstead, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound, Heart 976X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Self inflicted (25 cal.) (c) Sudden		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (State nature of injury in Part I or Part II of Item 18) apparently shot self in Heart	
20c. TIME OF INJURY Month, Day, Year Hour am. 3:00 p.m. 10/23 19 67	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Hampstead Carroll Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE William Speicher M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William Speicher		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 26, 1967	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Tipton-Eline Funeral Home		ADDRESS Hampstead, Md.	
25a. REC'D BY REGISTRAR OCT 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
22. DATE SIGNED 10-23-67		23e. STREET, CITY, TOWN, OR COUNTY 135 E. Main Street, Hampstead, Md.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

13749

13753

1. PLACE OF DEATH a. COUNTY Carroll MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Sykesville				c. LENGTH OF STAY IN lb 2y. 4m. 3d.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Springfield State Hospital				d. STREET ADDRESS - -			
3. NAME OF DECEASED (Type or print) Michael NMN Yatchyshyn				4. DATE OF DEATH Month 10 Day 28 Year 1967			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/11/82?-84?	9. AGE (In years lost birthday) 82?84? yrs.	11. BIRTHPLACE (County & State, or foreign country) Ukraine		12. CITIZEN OF WHAT COUNTRY? USA
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME ??Mitro Yatchyshyn (181-28-1617 A)				14. MOTHER'S MAIDEN NAME ?? Catherine Steinchak			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Address Springfield Hospital records, Sykesville	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Branchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH DAYS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) with psychotic reaction.					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 6/25/65 , 19____, to 10/28 , 1967, that (2) (we) last saw the deceased alive on 10/28 , 1967, and that death occurred at 7:30 PM , from causes and on the date stated above							
22a. SIGNATURE Ramon P. Lopez				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 10/28/67	
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez				22d. ADDRESS Springfield State Hospital Sykesville, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 10-31-67		23c. NAME OF CEMETERY OR CREMATORY Monogahela Mem. Park		23d. LOCATION (City or Town) (County) (State) DONORA PA.	
24. FUNERAL DIRECTOR Harry W. Haight Sykesville, Md.				25a. REC'D BY REGISTRAR DATE OCT 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

1973

RECORD OF DEATH

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County

State

Age

Sex

Marital Status

Occupation

Religion

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